Exhibit 13

1500

STATE FARM PO BOX 2361 BLOOMINGTON IL 61702

HEALTH INSURANCE CLAIM FORM

APPRIOVED BY NATIONAL	UNIFORM CLAIM	COMMITTEE	08:05
WILLIAMED DI HULIMING	· Atten Contai Actains	COMMITTEE	A

" T 'PICA		PICA ' 1 '
CHAMPUS -	UEAI TU DI AN DI VII ING	ta. INSURED'S LD. NUMBER (For Program in Item 1)
(Medicare *) (Medicaid *) (Sponsor's 55N) (Men		22 B127918 4. INSURED'S NAME (Last Namo, First Namo, Middle (ndat)
2. PATIENT'S NAME (Last Name, Fust Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	T. D. SMI Ind. S. I. T. T. Die. I. L. L. S.
5. PATIENT'S ADDRESS (No., Street)		7, INSURED'S ADDRESS (No., Siroti)
	Sch X Spouse Child Other	
	8. PATIENT STATUS Sunda X Married Other	
	Single X Married Other	
	Employed Student Student	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11 INSURED'S POLICY GROUP OR FECA NUMBER
A. OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
R, Other Maches Foliation of Charles	YES X NO	
b OTHER INSURED'S DATE OF BIRTH SEX		b. EMPLOYER'S NAME OR SCHOOL NAME
. , M F	XYES NO MI	
C. EMPLOYER'S NAME OR SCHOOL NAME	c, OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO II yos, rejuin to and complete item 9 a-d
READ BACK OF FORM BEFORE COMPLETS. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 purhous:	a the release of any medical or other intermation necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I nullhorize payment of medical benefits to the undereigned physician or supplier for
to process this claim. I also request payment of government banelus a below	either to myself or to the party who accepts assignment	services described below.
SIGNATURE ON FILE	DATE 04122010	SIGNATURE ON FILE
14. DATE OF CURRENT: ILLNESS (First symptom) OR	IS. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM . DD . YY 01062010	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
01062010 PREGNANCY(LMP) 17 NAME OF REFERRING PROVIDER OR OTHER SOURCE	01062010	PHOM TO SERVICES
17 NAME OF REFERRING PROVIDER ON GINEN 300NCE	17n. 17b. NPI	FROM TO
19 RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Retails lionis	3 L8471	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
1. <u>L847.0</u>		23. PRIOR AUTHORIZATION NUMBER
2 1 8 4 7 2	4.130981	
From To PLACE OF	OCEDURES, SERVICES, OR SUPPLIES E Explain Unusual Circumstances) EAGNOSIS	F. G. H. I. DAYS PROVIDER ID RENDEHING OF FORM U.A. PROVIDER ID
MM DD YY MM DD YY SERVCE EMG CPT	HÉPCS MODIFIÉR POINTER	S CHARGES LATIS PAY QUAL PROVIDER ID
01202010 01202010 11 99	205 25 1234	40000 1 NPI 1710019955
	, , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,
		NPI NPI
		NPI NPI
<u> </u>		NPI NPI
		, NPI
		1 1 550
25, FEDERAL TAX I,D. NUMBER SSN EIN 26, PATIEN	T'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29, AMOUNT PAID 30, BALANCE DUE
	41210JB003X YES NO	s 40000 s 000 s 40000
		33 BILLING PROVIDER INFO & PH # ()
(I certify that the statements on the reverse apply to this but and are made a part thereof.)		MICHIGAN VISITING PHYSICIANS 25650 W OUTER DRIVE
RAM GUNABALAN		LINCOLN PARK MI 48146-2096
SIGNATURE ON FILE	b	a.1841433588 b.
SIGNED DATE I		

1500

STATE FARM PO BOX 2361 BLOOMINGTON IL 61702

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		PICA Î I
TIPICA	A GROUP FECA OTHER IS, INSURED'S I.O. N	
1 MEDICARE MEDICAID TRICARE CHAMPY [Medicare #] [Medicare #] [Sponsor's SSN] [Member #]	HEALTH PLAN BLKLUNG	18
2. PATIENT'S NAME (Last Namo, Eus) Namo, Middle Initial)	3. PATIENT'S BIRTH DATE SEX 4 INSURED'S NAME	(Losi Namo, First Nome, Middle Iretal)
	MX F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRE	ESS (No., Street)
	Set X Spouse Child Other	
	6. PATIENT STATUS Signia X Mariled Other	
	Simple X Married Other	
	Employed Student Student	
9. OTHER INSURED'S NAME (Last Name, First Name, Mickel Install)		CY GROUP OR FECA NUMBER
IL OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE	OF BIRTH SEX
	YES X NO	TO DO
b. OTHER INSURED'S DATE OF BIRTH SEX	Lavor forth	ME OR SCHOOL NAME
: M_J	C. OTHER ACCIDENT?	I NAME OR PROGRAM NAME
C. EMPLOYER'S NAME OR SCHOOL NAME	, o' i la i i i i i i i i i i i i i i i i i	ARM
G, INSURANCE PLAN NAME OR PROGRAM NAME		ER HEALTH BENEFIT PLAN?
NA HAMMA BARRIM FRANCE AND AND AND AND A CAMPAGE AND AND A SALES AND AND A SALES AND AND A SALES AND AND A SALES AND AND AND AND A SALES AND	YES	NO # yos, return to and complete item 9 a-d
READ BACK OF FORM BEFORE COMPLETING 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: a unknown to process this clarm. I also request payment of government banefits either	release of any medical or other information necessary payment of modic	NTHORIZED PERSON'S SIGNATURE I authorize at bonetits to the undersigned physician or supplied for disclore.
SIGNATURE ON FILE		GNATURE ON FILE
SIGNED 14 DATE OF CURRENT: A ILLNESS (First symptom) OR 15.	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. 18 DATES PATIENT GIVE FIRST DATE MM 01062010 FROM	UNABLE TO WORK IN CURRENT OCCUPATION
14 DATE OF CURRENT: MM DD YY ALMSES (First symptom) OR 15. O 10 62 0 1 0 PREGNANCY(LMP)	GIVE FIRST DATE 01062010 FROM	то
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17	18, HOSPITALIZATIO	MY DATES HELYTED TO CONVENT SELVICES
17	NPI FROM 20, OUTSIDE LAB?	10 S CHARGES
19 NESERVED FOR LOCAL USE	YES	NO
21, DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate flems 1, 2		IBMISSION I ORIGINAL REF, NO
1, <u>33920</u> 3	18472 23, PRIOR AUTHOR	IZATION NUMBER
2. <u>8471</u> 24 A DATE(S) OF SERVICE B. C. D. PROC	EDURES, SERVICES, OR SUPPLIES E. F.	G. H I. J.
From To PLACE OF (Exp	pin Unusual Circumstances) DIAGNOSIS	G. H. I. J. DAVS EPBO! ID RENDERING OR Forty UNIS Han QUAL PROVIDER ID. #
MM DD YY MM DD YY SERVICE EMG I CP1/HC		
03012010 03012010 11 9921	3 25 123 250:00) 1 NPI 1710019955
	1 1 1	1 1 100
		I NPI
		I NPI
1 1 1 1 1		NPI NPI
		NPI NPI
	1	
	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28 TOTAL CHARGE	NPI 29. AMOUNT PAID 30. BALANCE DUE
25, FEDERAL TAX I.O. NUMBER	If or nort, clambs, the back	000 \$ 000 \$ 2500
	ACILITY LOCATION INFORMATION 33. BILLING PROVIDE	
INCLUDING DEGREES OR CREDENTIALS (I contry that the statements on the toverse	MICHIGA	N VISITING PHYSICIANS
anniv to this bill and are mode a part thereof.)	25650 W	OUTER DRIVE
RAM GUNABALAN SIGNATURE ON FILE		PARK MI 48146-2096
SIGNED DATE 8.	b	3588 <u>°</u>
NUCC Instruction Manual available at: www.nucc.org		

		STATE FARM INSURANCE
1500)		POBOX 2361 BLOOMINGTON IL 61702
HEALTH INSURANCE CLAIM FORM		BECOMINGION ID 01702
RPPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		PICA [TTT]
1. MEDICARE MEDICAID TRICARE CHAMPY	A GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicald #) CHAMPUS (Sponsor's SSN) (Member #	HEALTH PLAN BUK LUNG	22005M306
A DATICACTIO ALALAC (A	3. PATIENT'S BIRTH DATE SEX	4 INSURED'S NAME (Last Name, First Name, Middle (nittal)
5, PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self X:pouse Child Other	
1	8. PATIENT STATUS	ं
H	Single Married Other	20
	Employed Student Student	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11 INSURED'S POLICY GROUP OR FECA NUMBER
- OT 150 MOURENO 201/04/00 000/10 MINOSO	a EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
a. OTHER INSURED'S POLICY OR GROUP NUMBER	YES [X] NO	M X
b. OTHER INSURED'S DATE OF BIATH SEX	b. AUTO ACCIDENT? PLACE (State)	b EMPLOYER'S NAME OR SCHOOL NAME
C. EMPLOYER'S NAME OR SCHOOL NAME	C OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
G. EMPLOTER'S NAME ON SCHOOL NAME	VES XINO	STATE FARM INSURANCE
d INSURANCE PLAN NAME OR PROGRAM NAME	10d, RESERVED FOR LOCAL USE	d, IS THERE ANOTHER HEALTH GENEFIT PLAN?
READ BACK OF FORM BEFORE COMPLETING	A CICAMINA THIS ECOM	YES XNO Wyas, return to and complete item 9 and 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim, I also request payment of government benefits either	retease of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for services described below
below SIGNATURE ON FILE	02/15/11	SIGNATURE ON FILE
SIGNED	DATE	SIGNED
14. DATE OF CURRENT. ILLNESS (First symptom) OR 15 MM DD YY INJURY (Accident) OR PREGNANCY(LMP)	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 176	1 1	18, HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
JAMES BEALE 178	NPI 1316934409	FROM TO 20, OUTSIDE LAB? S CHARGES
19. RESERVED FOR LOCAL USE		YES TINO
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Herms 1, 2, 846 0	3 or 4 to Hem 24E by Line)	22. MEDICAID RESUBMISSION CRIGINAL REF. NO.
1, 3.	Ψ	23, PRIOR AUTHORIZATION NUMBER
729 1	1	
	DURES, SERVICES, OR SUPPLIES E. DIAGNOSIS	F. G. H. I. J. AENDERING
MM DD YY MM DD YY SERVEE EMG CPT/HCP		\$ CHARGES UNITS PER QUAL G PROVIDER ID. #
01; 20;11 01 20 11 11 99205	5	300, 00 1
		NPI NPI
		NPI NPI
		NPI NPI
		NPI NPI
OF SERVIN TAXAD MUNDED. CON EN. 100 DATEMENT	COCCUMITATO 127 ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
25. FEDERAL TAX 10. NUMBER SSN EIN 26. PATIENT'S A PRAMA 000	2996 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 300, . 00 29. AMOUNT PAID 30. BALANCE DUE 3 00, . 00
INCHIDING DECORES OR CORDENTIALS	CILITY LOCATION INFORMAT(248)354-1111	33. BILLING PROVIDER INFO & PH # (586) 2684833
(i certify that the statements on the reverse MEDICAL I	EVALUATIONS PC ST NINE MILE ROAD	DR JAMES BEALE JR. MD 11111 HALL ROAD SUITE 101
DR. DAMES BEALE. N. D SOUTHFIRE	LD MI 48076	UTICA, MI 48317
02/15/11 signed DATE a.	b.	a. 1316934409 b. Q2
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

		STATE FARM INSURANCE
(1500)		POBOX 2361
HEALTH INSURANCE CLAIM FORM		BLOOMINGTON IL 61702
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		
PICA		PICA [
1. MEDICARE MEDICAID TRICARE CHAMP	HEALTH PLAN REKILING	1a. INSURED'S LD NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member	<u>' </u>	22005M306
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIATH DATE SEX	4_INSURED'S NAME 0.ast Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6, PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No., Skeet)
S. F. KIRCH & REDITATION FIRST CONTROL	Self Moouse Child Other	
	8, PATIENT STATUS	d
	Single Married Other	
[]		Z
	Employed Student Student	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	11 INSURED'S POLICY GROUP OR FECA NUMBER
B. OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
	☐ YES X NO	
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	B EMPLOYER'S NAME OR SCHOOL NAME
M F	A STUD ASSISTED NO LINO	C INSURANCE PLAN NAME OR PROGRAM NAME
o, EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	STATE FARM INSURANCE
d INSURANCE PLAN NAME OR PROGRAM NAME	10d RESERVED FOR LOCAL USE	d is there another health benefit plan?
G INDOMANCE PENN NAME OF LUDGIUM NAME	TOU NEGET VED TON COOKE OUG	YES NO If yes, return to and complete item 9 a-d
READ BACK OF FORM BEFORE COMPLETIN	IG & SIGNING THIS FORM.	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
12, PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either	e release of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for services described below
below.	and the second s	SIGNATURE ON FILE
SIGNATURE ON FILE	DATE 04/17/11	SIGNED
14. DATE OF CURRENT: /ILLNESS (First symptom) OR 15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
OT TO ZOTT PREGNANCY(LMP)	GIVE TIME	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17. JAMES BEALE		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
	1316934409	FROM TO 1 20, OUTSIDE LAB? \$ CHARGES
19, RESERVED FOR LOCAL USE		VES TYNO I
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2	2.3 or 4 to item 24E by Line)	22 MEDICAID RESURMISSION
, 846 0	+	CODE ORIGINAL REF NO
1	J. L.	23. PRIOR AUTHORIZATION NUMBER
2 729 1	· I	
24. A. DATE(S) OF SERVICE B. C. D PROC	EDURES, SERVICES, OR SUPPLIES E.	F. G H I. J. DAYS FROM ID RENDERING
From To PLACE OF (Exp		S CHARGES UNITS PM QUAL PROVIDER ID. #
03 10 11 03 10 11 11 992	14 12	16 150 00 1 NPI 1316934409
		, , , , , , , , , , , , , , , , , , , ,
		NPI
3 1 1 1 1 1 1 1	1 1 1 1	l l NPI
		THE
		NPI NPI
		4
		NPI NPI
		NPI NPI
		NP!
	trer gove craims, see oeco	28 TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
382264186 X PRAMAO	00 3166 Xes No	28 TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 150.00 \$ \$ 150.00
382264186 X PRAMAO	00 3166 Xes No	29. AMOUNT PAID 30. BALANCE DUE \$ 150.00 \$ \$ 150.00 \$ \$ 150.00 \$
382264186 PRAMAO 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse MEDICAL	00 3166 Kes No ACILITY LOGATION INFORMATION (248)354-1111 EVALUATIONS PC	28 TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 150.00 \$ \$ 150.00 \$ 150.0
382264186 PRAMAO 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I) Certify that the statements on the reverse apply to this bill and are made a part thereof.) DR. TAMES REALE M.D. 17117 W	3166 SES NO ACILITY LOCATION INFORMATION (248) 354-1111 EVALUATIONS PC EST NINE MILE ROAD	29. AMOUNT PAID 30. BALANCE DUE s 150.00 s s 150.00 s 150.00 c pue s 150.00 a ph * (586) 2684833 DR JAMES BEALE JR. MD 11111 HALL ROAD SUITE 101
382264186 PRAMAO 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I) Certify that the statements on the reverse apply to this bill and are made a part thereof.) DR. TAMES REALE M.D. 17117 W	00 3166 Kes No ACILITY LOGATION INFORMATION (248)354-1111 EVALUATIONS PC	28 TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 150.00 \$ \$ 150.00 \$ 150.0

2:14-cv-11700-PDB-MJH Doc # 1-14 Filed 04/29/14 Pg 6 of 9 Pg ID 192

1500

STATE FARM INSURANNE POBOX 2361

Rectand #1 Rec	HEALTH INSURANCE CLAIM FORM		BLOOMINGTON IL 61702
1. MEDICANE LIZEDICALD THOCHES SUI CHAMPIA GROUP PLAN GROUP CONTROL TO SAN of 10. MARCH CAR MARC	PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		
Modification at Modification at Modification at Modification at Modification at	* * PICA		PICA
DATE INSURED'S ADDRESS (No. Street) A PATIENT STADULE Supple Manned Order	CHAMPUS C	DE ALTU DI AM DE L'IL 1970	1
Seri	PATIENT'S NAME (Lost Name, First Name, Mids0e Initizi)		4 INSURED S NAME (Lastitume, Four Name, Middle Inde)
OTHER INSURED'S NAME (Last Name, First Name, Middle Install) OTHER INSURED'S POLICY OR GROUP NUMBER a EMPLOYMENT? (Current of Previous) OTHER INSURED'S DATE OF BIRTH SEX M F OR AUTO ACCIDENT? C. OTHER ACCIDENT? PLACE (State) DEMPLOYER'S NAME OR SCHOOL NAME C. OTHER ACCIDENT? PLACE (State) DEMPLOYER'S NAME OR PROGRAM NAME OCCUPATION OF AUTO ACCIDENT? OCCUPATION OCCUPATION PESS NO C. OTHER ACCIDENT? PLACE (State) DEMPLOYER'S NAME OR SCHOOL NAME C. OTHER ACCIDENT? OCCUPATION	PATIENT'S ADDRESS (No., Stroct)	Sc4 X Spouse Ch. d Other 8. PATIENT STATUS Single Marned Other Full-Time Pert-Time	7 INSURED'S ADDRESS (No . Street)
OTHER INSURED'S DATE OF BIRTH SEX M F BAUTO ACCIDENT? PLACE (State) P	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11 INSURED'S POLICY GROUP OR FECA NUMBER
EMPLOYER'S NAME OR SCHOOL NAME EMPLOYER'S NAME OR SCHOOL NAME C. OTHER ACCIDENT? C. OTHER ACCIDENT. C.	. OTHER INSURED'S POLICY OR GROUP NUMBER		
YES X NO STATE FARM INSURANNE 10d RESERVED FOR LOCAL USE d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO # yes, return to and complete item 9 and process this claim 1 also request payment of povernment benefits either to mysed or to the party who accepts assignment SIGNATURE		PLACE (State)	b EMPLOYER'S NAME OR SCHOOL NAME
PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize the richard of any mid data or other information necessary to process this claim I also request payment of government benefitie either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 10/23/09 SIGNATURE ON FILE SIGNED DATE 10/23/09 SIGNATURE ON FILE SIGNED A DATE OF CURRENT PREGNATORIZED PERSON'S SIGNATURE I authorize the richard of any mid data or other information necessary to process this claim. I also provide request payment of government benefitie either to myself or to the party who accepts assignment services described below. SIGNATURE ON FILE SIGNED SIGNATURE ON FILE SIGNED A DATE OF CURRENT PREGNATORIZED PERSON'S SIGNATURE I authorized physicish or supplies centeed described below. SIGNATURE ON FILE SIGNED SIGNATURE ON FILE SIGNATURE ON FILE SIGNED SIGNED SIGNATURE ON FILE SIGNED SIGNATURE ON FILE SIGNED SIGNED SIGNATURE ON FILE SIGNED SIGNATURE ON FILE SIGNED SIGNED SIGNED SIGNATURE ON FILE SIGNED SIGNATURE ON FILE SIGNED SIGNED SIGNATURE ON FILE SIGNED SIGNED SIGNATURE ON FILE SIGNATURE ON	EMPLOYER'S NAME OR SCHOOL NAME	YES X NO	STATE FARM INSURANNE
PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I cuchorzo the release of any mild dat or other normation necessary to process this claim I also request payment of government benefits either to mycel or to the party who accepts assignment below SIGNATURE ON FILE 10/23/09 SIGNATURE ON FILE 10/23/09 SIGNATURE ON FILE SIGNED 4. DATE OF CURRENT 72 7 20 09 ILLNESS (First synchrom) OR PREGNANCY (LMFL N JURY Accident) CO PREGNANCY (LMFL N JURY PREGNANCY (LMFL N JURY Accident) CO PREGNANCY (LMFL N JURY ACC	INSURANCE PLAN NAME OR PROGRAM NAME	10d RESERVED FOR LOCAL USE	YES X NO # yee, return to and complete item 9 a-d.
4. DATE OF CURRENT 7 2 7 2009 PREGNANCY(LMF) NJURY REGNANCY(LMF) N	2 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize this to process this claim 1 also request payment of government benefits either before	erclinane of any modulation other information necessary into myself or to the party who accepts assignment	payment of modical benefits to the undertigned physician or supplier for cervices described below
7 NAME OF REFERRING PROVIDER OR OTHER SOURCE NORTH ROUNCE	SIGNED	DATE	SIGNED
PRESERVED FOR LOCAL USE 17b NPI 17b NPI 17b NPI 17b NPI 20 OUTSIDE LAB? 17c CODE 17c NO 21c OUTSIDE LAB? 17c NO 22c MEDICAID RESUBMISSION 17c ORIGINAL REF. NO. 23c PRIOR AUTHORIZATION NUMBER 17c OF SERVICE 17c OF SERVICE 17c OF SERVICES 17c OF S	S. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR INJURY (Accident) OR PREGNANCY (LMFINJURY	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	FROM TO
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 3. 796.2 22 MEDICAID RESUBMISSION ORIGINAL REF. NO. 23 PRIOR AUTHORIZATION NUMBER 4. A DATE(S) OF SERVICE From From From To RACECF (Explain Unusual Circumstances) MM DD YY MM DD YY SERVE EMG CPT/HCPCS 1. CODE POINTER S CHARGES CASE PROVIDER ID ORIGINAL REF. NO. ORIGINAL	NIDDEN DITTEN MD	+ +	
3, 796 2 23 PRIOR AUTHORIZATION NUMBER 24 A DATE(S) OF SERVICE From To RACECT (Explan Unusual Circumstances) M DD YY MM DD YY SERVE EVG CPT/HCPCS 1 MODIFIER POINTER S CHARGES LATS FOR DOAL PROVIDER ID	9. RESERVED FOR LOCAL USE		(**
2. 9 0 0 9 4 L 4 A DATE(S) OF SERVICE From To RACECF (Explorin Unusual Circumstances) M DD YY MM DD YY SRV3E EMG CPT/HCPCS MODIFIER POINTER S CHARGES CONTINUE CONTINU	·	·	CODE ORIGINAL REF. NO.
AM DD YY MM DD YY SERVE EMG CPTHCPCS MODIFIER POINTER SCHARGES LATS F OUAL PROVIDER ID	4. A DATE(S) OF SERVICE 8 C. D PROC	EDURES, SERVICES, OR SUPPLIES E.	F G H J J. DENOGRANG
$3 \ 17 \ 09 \ 08 \ 17 \ 09 \ 111 \ 199205 \ 123 \ 300 \ 00 \ 1 \ 1891 \ 1891 \ 1991 $	MM DD YY MM DD YY SERVOE EMG CPT/HC	PCS LAODIFIER POINTER	SCHARGES LATS F TOUAL PROVIDER ID #

- 1		YES X NO	STATE FARM INSURANNE
t	I. INSURANCE PLAN NAME OR PROGRAM NAME	10d RESERVED FOR LOCAL USE	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
1		j	YES X NO # yes, return to and complete item 9 a-d.
	READ BACK OF FORM BEFORE COMPLETING PATIENTS OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the to process this claim. I also request payment of government benefits either.	e release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthonze payment of moducal benefits to the undersigned physician or supplier for cerviced decirabed below
1	below SIGNATURE ON FILE	10/23/09	SIGNATURE ON FILE
1	SIGNED	DATE	SIGNED
ģ	PREGNANCY(LMPLINUURI	F PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD TO
	MIDDEN DITTEN MD	70 NPI	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
Ī	19. RESERVED FOR LOCAL USE	· ·	20 OUTSIDE LAB? \$ CHARGES
L		,	YES NO
ľ	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Hems 1, 2	2, 3 or 4 to Rem 24E by Line)	22 MEDICAID RESUBMISSION ORIGINAL REF. NO.
1			23 PRIOR AUTHORIZATION NUMBER
١.	2 900 9		F G H I J.
- [EDURES, SERVICES, OR SUPPLIES Ilain Unusual Circumstances) PCS L.ODIFIER POINTER	I some things I
ا _و ر	8 17 09 08 17 09 11 9920	5 123	300 00 1 NPI
2 ₀	9 14 09 09 14 09 11 9921	4 123	200 00 1 NP;
3		<u> </u>	NPI NPI
4			NPI
5			! NPI
- 3		! ,	NPt
	5. FEDERAL TAX I D NUMBER SSN EN 26. PATIENTS 64300636 X CAMLA000	ACCOUNT NO 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AMOUNT PAID 30 BALANCE DUE \$ 500.00
	IN SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I cently that the catements on the reverse NDREW RUDEN MAD part thereof)	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (248 3541111 MEDICAL EVALUATIONS, P.C 20411 TWELVE MILE ROAD 103
į,	10/23/09		SOUTHFIELD, MI 48076
- 1	EGNED DATE	[2	a ; G2

1500		STATE FARM INSURANCE POBOX 2361
HEALTH INSURANCE CLAIM FORM		BLOOMINGTON IL 61702-9738
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		
T T PICA		PICA
1 MEDICARE MEDICAID TRICARE CHAMPVA (Medicare #) (Medicard #) (Sponsor's SSN) (Member IDI)	- HEALTH PLAN - BLK LUNG reas	1a INSURED'S I.D. NUMBER (For Program in Item 1) 22012N185
2 PATIENT'S NAME (Last Name, First Name, Mxid'e Initial)	3 PATIENT'S BIRTH DATE SEX	4. (NSURED'S NAME (Lest Namo, Einst Namo, Middle Initial)
5 PATIENT'S ADDRESS (No , Street)	M FX	7. INSURED'S ADDRESS (No., Street)
7 ATICKT S ADDRESS (NO., Slieet)	6 PATIENT RELATIONSHIP TO INSURED 6elf X Spouse Chad Other	/ NSURED S ADDRESS INC. SITERIA
 	8. PATIENT STATUS	C
	Single Married Other	-
	Employed Student Student Student	Z
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10 IS PATIENT'S CONDITION RELATED TO	11 INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	- CHOLONGENTO IO	a INSURED'S DATE OF BIRTH SEX
2. OTHER TIMESURED S POLICY ON GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES (X) NO	a INSURED'S DATE OF BIRTH SEX
b. OTHER INSURED'S DATE OF BIRTH SEX	السما المسا	b. EMPLOYER'S NAME OR SCHOOL NAME
	X YES NO NO	WOOD AND ALL HAND OF PROPERTY.
C. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
DEAD DACK OF FORM SERVICE OF THE	- CONTROL THE CODE	YES X NO If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING: 1 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the rel to process this claim. I also request payment of govamment benefits either to	ilease of any medical or other information necessary	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical banelits to the undersigned physician or supplier to services described below.
below SIGNATURE ON FILE	05/18/ 11	SIGNATURE ON FILE
SIGNED	DATE	SIGNED
14. DATE OF CURRENT: O4" 0 60 2 0 1 1" (ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	TO THE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD DD DD TO MM DD TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD CONTROL OF THE CONTRO
19. RESERVED FOR LOCAL USE	NPI	FROM TO CONTROL LAB? S CHARGES
		YES X NO
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 . 847 0	or 4 to (tem 24E by Line) 719 41	22. MEDICAID RESUBMISSION ORIGINAL REF. NO
3. L 846 9		23. PRIOR AUTHORIZATION NUMBER
24	784 0	
	URES, SERVICES, OR SUPPLIES Unusual Circumstances) S MODIFIER POINTER	F G. H. I. J OA'S EFSOT ID RENDERING OR FORY OUAL PROVIDER ID #
A A A A A A A A A A A A A A A A A A A		1.6
4 19 11 04 19 11 11 99205	1234	300 00 1 NPI 1144429762
		NPI NPI
		NPI NPI
		ุ มคา
' ' 1 : 1 1 1	1 ' ! ! 1	-
		NPI
		NPI NPI
5 FFDERAL TAX LD NUMBER SSN EIN 26 PATIENT'S AC	647 X Tor govt comma con back	28 TOTAL CHARGE 300.00 s 300.00
	YES NO NO NO NO NO NO NO NO	33 BILLING PROVIDER INFO & PH # 586-268-4833
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	N CLINIC PC	MUNDY PAIN CLINIC P.C. 6240 RASHELLE DRIVE SUITE 103
SEAN HOBAN M.D 6240 RASHE	ELLE DRIVE SUITE 103	
05/18/11 FLINT MI	48507	FLINT, MI 48507 a. 1144429762 b.

	1 1	1				1		! !		INPI	
	<u> </u>	.l	i		L	<u> </u>		<u> </u>	<u> </u>	NPI NPI	
- 		1			<u>i</u>	<u> </u>	L <u> </u>	<u> </u>			
	1 1	1	<u> </u>		i	1			I	NPI -	
	Y SERVICE EMG		<u>.</u>	MODIFIE	}	POINTER	\$ CHARGE		¥nTs Pom	OUAL IG	PROVIDER ID. #
A DATE(S) OF SERVICE	B C.			/ICES, OR SU	PPLIES	E. DIAGNOSIS	F	0	G H. AYS EPSO OR Ferral WITS Pear	1.	J. RENDERING
723 4		3.	718	81		*	23. PRIOR AU	THORIZATIO	N NUMBE	R	
DIAGNOSIS OR NATURE OF ILLNES	S OR INJURY (Rela	ate Items 1, 2, 3	or 4 to Item :	24E by Line)			22. MEDICAID		SION	GINAL REF.	. NO.
RESERVED FOR LOCAL USE		176.	1.45-1			<u></u>	20. OUTSIDE 1	AB?		\$ CHA	AGES
NAME OF REFERRING PROVIDER O			NPI					ZATION DA	TES RELA		RRENT SERVICES
YRUKNI) AYYC LAM COM	(First symptom) OR Accident) OR NCY(LMP)	15. 11		AS HAD SAM	OR SIM	LAR ILLNESS		FIENT UNA	SLE TO WO	TO	RENT OCCUPATION
below. SIGNATURE			ĎΑ	04	/24/	_	SIGNED			ON F	ILE
PATIENT'S OR AUTHORIZED PERSO to process this claim. I also request pay	FFORM BEFORE (DN'S SIGNATURE I	authorize the re	elease of any	medical or other	r informati	on necessary signment	payment of	OR AUTHO medical ben scribed below	efits to the	RSON'S SIO	SNATURE I authorize I physician or supplier for
NSURANCE PLAN NAMÉ OR PROGR	AM NAME		10d. RESER	VED FOR LO	CAL USE		d, IS THERE A	XNo	If yes	, return to a	nd complete item 9 a-d
EMPLOYER'S NAME OR SCHOOL NA			c. OTHER A	YES	X		c INSURANCE STATE	FARM	INSUR	ANCE	
MM DD YY	M F			YES	NC	PLACE (State)	b, EMPLOYER				
OTHER INSURED'S DATE OF BIRTH			b. AUTO AC	MENT? (Curren	X	1	a, INSURED'S		,,,,,,	M [] **
OTHER INSURED'S POLICY OR GRO		o hundij		NT'S CONDIT							SEX
OTHER INSURED'S NAME (Last Name	First Name 12:2-9	o Initio	Employed	Full-Tim Student	s	udent	11. INSURED'S	BOLICY C	SOUP OF 1	EECA NI ISA	SFR
<u></u>			Single	Marrie	d 🗌	Other	ZIF				
$\overline{\mathbf{r}}$			Sell X		Child	Other	Ci Ci				
PATIENT'S ADDRESS (No., Street)			6. PATIENT	RELATIONSH	IP TO INS	F X URED	7 INSURED'S	ADDRÉSS (No., Street)	
(Medicare #) (Medicaid #) ATIENT'S NAME (Last Name, First N	(Sponsor's \$\$N)	(Member ID	(SSN	OF ID)	(SSN)	X (ID)	22B09 4.JNSURED'S		Nama Fire	t Name, Mic	idie Initial)
MEDICARE MEDICAID	TRICARE CHAMPUS	CHAMPVA	- HEAL	UP TH PLAN	FECA BUX LUN	G	1a. INSURED'S		ER	{	PICA For Program in Item 1)

1500) HEALTH INSURANCE CLAIM FORM	STATE FARM INSURANCE POBOX 2361 BLOOMINGTON IL 61702-9738
AFPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	PICA FTTT
	1s. INSURED'S ID NUMBER (For Program in Item 1)
[Medicare #) [Medicard #) [Sponsor's SSN] [Member ID#) [SSN or ID] [SSN] [ID]	22012N185
2. PATIENT'S NAME (Last Name First Name Middle Initial) 3. PATIENT'S BIRTH DATE SEX	4. NSURED'S NAME (Last Name, First Name, Middle Initial)
	7. INSURED'S ADDRESS (No. Street)
Self X Spouse Child Other	_
8. PATIENT STATUS Single Married Other	C)
	216
Employed Student Student	11 INSURED'S POLICY GROUP OR FECA NUMBER
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO	1) INSURED S POLICY GROOP ON PEON NUMBER
	ZIF 11 INSURED'S POLICY GROUP OR FECA NUMBER 2 INSURED'S DATE OF BIRTH 3 INSURED'S DATE OF BIRTH 4 INSURED'S DATE OF BIRTH 5 EX 5 EMPLOYER'S NAME OR SCHOOL NAME 5 INSURANCE PLAN NAME OR PROGRAM NAME 5 TATE FARM INSURANCE d IS THERE ANOTHER HEALTH BENEFIT PLAN?
b. OTHER INSURED'S DATE OF BIRTH SEX b. AUTO ACCIDENT? PLACE (State)	M X D. EMPLOYER'S NAME OR SCHOOL NAME
MM DD YY SEX PLACE (State)	B. EMPLOTER STRANG ON BUTTOUL WAIRE
	c INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE
YES NO	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
	YES X NO If yes, return to and complete item 9 a.d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. It also request payment of government benefits either to myself or to the party who accepts assignment below.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below
SIGNATURE ON FILE DATE 06/27/11	. SIGNATURE ON FILE
14. DATE OF CURRENT 4 (LLNESS (First symptom) OR 15. IF PATIENT HAS HAD SAME OR SIMILAR ILL NESS.	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
PREGNANCY(LMP)	FROM TO
178 175, NAME OF REPERHING PROVIDER OR OTHER SOURCE 178	THE HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
	20, OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	YES NO 22. MEDICAID RESUBMISSION
1 1 847 0 3 1 719 41	OPIGINAL REF. NO
	23 PRIOR AUTHORIZATION NUMBER
2	F. G. H. I J.
From To PLACE OF (Explain Unusual Circumstances) DIAGNOSIS MM DD YY MM DD YY SERVCE EMG CPT/HCPCS MODIFIER POINTER	F. G. H I J DAYS REPORT ID. RENDERING OR Frmily S CHARGES LATE PROVIDER ID #
06 02 11 06 02 11 11 99213 1234	100 00 1 NPI
	l NPI
	No.
	NPI NPI
	, NPI
	NPI NPI
	i NPI
(For poyt, claring, page back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
200394435 X WILHAUUU 752 X YES NO	\$ 100.00 \$ \$ 100.00 33. BILLING PROVIDER INFO & PH# \$86 268 4833
INCLUDING DEGREES OR CREDENTIALS	33. BILLING PROVIDER INFO & PH # \$86 \$468 4833 MUNDY PAIN CLINIC P.C.
(Certify that the statements on the revertee profit to the bit and are made a part thereot.) MARTIN QUIROGA D.O. MUNDY PAIN CLINIC PC 6240 RASHELLE DRIVE SUITE 103	6240 RASHELLE DRIVE SUITE 103
06/27/11 FLINT MI 48507	FLINT, MI 48507
SIGNED DATE 8. D.	